

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet) or by calling 1-800-ASK-BLUE (TTY:711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For <a href="#">In-Network providers</a> \$2,950 person / \$4,400 person and dependent / \$5,900 family.	You must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay the overall EE Only, EE/Child or Family (Incl. EE/Sp/DP & EE/Children & Family) <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For <a href="#">In-Network providers</a> \$4,500 person / \$6,750 person and dependent / \$9,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If enrolled in this <a href="#">plan</a> , the overall EE Only, EE/Child or Family (Incl. EE/Sp/DP & EE/Children & Family) <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.ibx.com/find_a_provider">www.ibx.com/find_a_provider</a> or call 1-800-ASK-BLUE (TTY:711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	25% <a href="#">coinsurance</a> .	Not covered.	Telemedicine (from designated telemedicine provider, <a href="http://www.ibx.com/findcarenow">www.ibx.com/findcarenow</a> ): 25% <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	25% <a href="#">coinsurance</a> .	Not covered.	None
	<a href="#">Preventive care/screening</a> /immunization	No charge. <a href="#">Deductible</a> does not apply.	Not covered.	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">coinsurance</a> .	Not covered.	None
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required for certain services. *See section General Information. 20% reduction in benefits for failure to precert BlueCard services.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ibx.com/formulary3S">http://www.ibx.com/formulary3S</a> .	Generic Drugs	Retail/Mail Order (1-30 days supply) 25% <a href="#">coinsurance</a> . Mail Order (31-90 days supply) 25% <a href="#">coinsurance</a> .	Not covered.	Prior authorization required on some drugs; age and quantity limits may apply; 30 days supply limit on retail & 90 days supply on mail order for maintenance drugs.
	Preferred Brand	Retail/Mail Order (1-30 days supply) 25% <a href="#">coinsurance</a> . Mail Order (31-90 days supply) 25% <a href="#">coinsurance</a> .	Not covered.	
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) 25% <a href="#">coinsurance</a> . Mail Order (31-90 days supply) 25% <a href="#">coinsurance</a> .	Not covered.	
	<a href="#">Specialty Drugs</a>	25% <a href="#">coinsurance</a> .	Not covered.	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in a home/office or outpatient facility. Self-administered <a href="#">specialty drugs</a> that are covered under the pharmacy benefit follow the applicable retail prescription cost-share under the Specialty Pharmacy

\*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Program. Prior-authorization required. *See section Outpatient Services.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a> .	Not covered.	Precertification may be required. *See section General Information. 20% reduction in benefits for failure to precert BlueCard services.
	Physician/surgeon fees	25% <a href="#">coinsurance</a> .	Not covered.	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	25% <a href="#">coinsurance</a> .	Covered at In-Network level.	None
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a> .	Covered at In-Network level.	
	<a href="#">Urgent care</a>	25% <a href="#">coinsurance</a> .	Not covered.	Your costs for <a href="#">urgent care</a> are based on care received at a designated <a href="#">urgent care</a> center or facility, not your physician's office. Costs may vary depending on where you receive care.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services.
	Physician/surgeon fees	25% <a href="#">coinsurance</a> .	Not covered.	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office: 25% <a href="#">coinsurance</a> . All Other Services: 25% <a href="#">coinsurance</a> .	Office: Not covered. All Other Services: Not covered.	Precertification may be required. 20% reduction in benefits for failure to precert BlueCard services.
	Inpatient services	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services.
<b>If you are pregnant</b>	Office visits	25% <a href="#">coinsurance</a> .	Not covered.	Office visit cost share applies to the first OB visit only. Depending on the type of services, additional <a href="#">copayments</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a> .	Not covered.	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a> .	Not covered.	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services.
	<a href="#">Rehabilitation services</a>	25% <a href="#">coinsurance</a> .	Not covered.	20% reduction in benefits for failure to precert BlueCard services. Physical/Occupational Therapies: 60 visits combined/Calendar Year. Speech Therapy: 20 visits/Calendar Year. Visit limits do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.

\*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	25% <a href="#">coinsurance</a> .	Not covered.	20% reduction in benefits for failure to precert BlueCard services. Physical/Occupational Therapies: 60 visits combined/Calendar Year. Speech Therapy: 20 visits/Calendar Year. Visit limits do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services. 120 visits/Calendar Year.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required for selected items. *See section General Information. 20% reduction in benefits for failure to precert BlueCard services.
	<a href="#">Hospice services</a>	25% <a href="#">coinsurance</a> .	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge. <a href="#">Deductible</a> does not apply.	\$40 reimbursement.	Once every two years.
	Children's glasses	No charge. <a href="#">Deductible</a> does not apply.	\$50 reimbursement.	None
	Children's dental check-up	Not covered.	Not covered.	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Cosmetic surgery	• Hearing aids	• Routine foot care
• Dental care (Adult)	• Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Acupuncture	• Infertility treatment (limited to artificial insemination)	• Private-duty nursing
• Bariatric surgery	• Non-emergency care when traveling outside the U.S. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a>	• Routine eye care (Adult)
• Chiropractic care		

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. To contact the [plan](#) at 1-800-ASK-BLUE (TTY: 711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-

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444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); For non-federal governmental group health [plans](#), contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State Insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Pennsylvania [Health Insurance Marketplace](#), visit [www.Pennie.gov](http://www.Pennie.gov) or call 1-844-844-8040.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); for non-federal governmental group health [plans](#) and church [plans](#) that are group health [plans](#), contact us at 1-800-ASK-BLUE (TTY:711); if the coverage is insured, you may also contact the Pennsylvania Insurance Department - 1-877-881-6388 - <http://www.insurance.pa.gov/Consumers>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet Minimum Value Standards?**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet).

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,950	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,950	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,950
■ <a href="#">Specialist coinsurance</a>	25%	■ <a href="#">Specialist coinsurance</a>	25%	■ <a href="#">Specialist coinsurance</a>	25%
■ Hospital (facility) <a href="#">coinsurance</a>	25%	■ Hospital (facility) <a href="#">coinsurance</a>	25%	■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%	■ Other <a href="#">coinsurance</a>	25%	■ Other <a href="#">coinsurance</a>	25%
<p>This EXAMPLE event includes services like:  <a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,950	<a href="#">Deductibles</a>	\$2,950	<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,600	<a href="#">Coinsurance</a>	\$600	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,520</b>	<b>The total Joe would pay is</b>	<b>\$3,570</b>	<b>The total Mia would pay is</b>	<b>\$2,800</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711)

